

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Diat. No. 190

1. PLACE OF DEATH: Howard
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....md County.....Howard
 City or town.....Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....st stephens
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....F 5. Color or race.....C 6.(a) Single, married, widowed, or divorced.....Widow
 6.(b) Name of husband or wife.....Alfred Blackstone
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....1876
 8. AGE: Years.....69 Months.....7 Days.....7 It less than one day..... hrs. min.

8. Birthplace.....Maryland
 (Town, county, and state)
 10. Usual occupation.....at home

11. Industry or business

12. Name.....Samuel Steward
 13. Birthplace.....md.
 14. Maiden name.....unknown
 15. Birthplace.....11

16. Informant.....John Blackstone
 Address.....Elkridge md

17. Burial.....Burial Date thereof.....4-12-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Blackstone
 Location.....Elkridge md
700 N. Myndalham

18. Funeral director.....Elmott City md
 Address.....

19. April 11 1945 (Miss) E. Bird William
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 10 1945 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 6 1945 to April 10 1945
 and that I last saw him alive on April 10 1945

Immediate cause of death.....Arterio Sclerosis

Due to.....hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....John Blackstone M.D.
 M. D. or other

Address.....Elkridge md Date signed.....4-11-45

RECEIVED
APR 16 1945
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04015

Reg. Dist. No. 192

1. PLACE OF DEATH:

County Howard
City or town Glenwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2.5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Howard
City or town Glenwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Bertie M. Campbell

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Charles P. Campbell Jr.
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1876

8. AGE: Years 68 Months 4 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Dennis L. Smith

13. Birthplace Fredrick Co. Md.

14. Maiden name Sue Long

15. Birthplace Maryland

16. Informant Charles P. Campbell
Address Glenwood, Md.

17. Burial Date thereof Apr 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Grove Cem.

Location Glenwood Md.

18. Funeral director Easton Sons
Address Edlitt City, Md.

19. April 10 1945 Alvin H. Hebb
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/45 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/9/45 1945 and that I last saw him alive on no date 1945

Immediate cause of death Coronary Thrombosis DURATION 2 hrs.

Due to Arteriosclerotic Cardiovascular Disease 2 yrs.

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George E. Binstorf M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY. D. of other
Address Edlitt City, Md. Date signed 4/9/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14
APR 28 1949
STEELE V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

04016

Reg. Dist. No. 198

1. PLACE OF DEATH:

County... Howard
 City or town... Savage Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... HowardCity or town... Savage
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lamont Frank Frazier

3. (b) Social Security Number

4. Sex White 5. Color or race Male 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 69 Months 9 Days 10 It less than one day
 hrs. min.

8. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 9th, 1945, at 8:00 PM
 I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Dec. 12, 1944, to April 9th, 1945
 and that I last saw him alive on April 9th, 1945

Immediate cause of death

Cerebral Embolism

DURATION

5 days.

Due to

Cowberry Thrombosis1 yr.

Due to

Hypocretal Insuff.4 mos.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Frank Shipley, M.D.

M. D. or other

Date signed 4/10/45

RECEIVED

MAY 4 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH: *Howard*
 County.....
 City or town.....*Garage*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*37 yrs.*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Howard*
 City or town.....*Garage*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Thomas J. Hitt*

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *widowed*

6. (b) Name of husband or wife *Mary F.*

7. Birth date of deceased (mo., day, yr.) *Oct-17-1861* 6. (c) If alive, give age..... years

8. AGE: Years *83* Months *5* Days *27* If less than one day
 hrs. min.

9. Birthplace *Virginia*
 (Town, county, and state)

10. Usual occupation *farmer*

11. Industry or business *retired*

12. Name *Joseph Hitt*

13. Birthplace *La Va*

14. Maiden name *Emily Mundy*

15. Birthplace *La Va*

16. Informant *John Hitt*

Address *Garage Md.*

17. Burial Date thereof *Apr-15-45*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Garage Md.*

Location *Garage Md.*

18. Funeral director *Woods Kaiser*

Address *Lakeside*

4/14/45

19. (Data rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 13* 19 *45* at *11:52 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *10-20* 19 *39*, to *4-13* 19 *45*
 and that I last saw him alive on *4-12* 19 *45*

Immediate cause of death *Cerebral Thrombosis* DURATION *5 days*

Due to *Arteriosclerosis*

Due to

Other conditions *prostatic Carcinoma 2 yrs*

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *M. Marcus M.D.*

Address *Laurel, Md.* Date signed *4/13/45*

MARGIN RESERVED FOR BINDING

VS A15

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RECEIVED

MAY 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57

CERTIFICATE OF DEATH

04018

Reg. Diat. No. 190

1. PLACE OF DEATH:

County Howard
 City or town Elkridge (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Montgomery Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leonard Miller

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, or divorced

M W married

6.(b) Name of husband or wife Anna M. Miller7. Birth date of deceased (mo., day, yr.) Apr. 16, 1858 8.(c) If alive, give age years

8. AGE: Years 86 Months 11 Days 28 If less than one day
 hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Geo. Miller13. Birthplace Germany14. Maiden name Eliz. Zeisert15. Birthplace Germany16. Informant Anna M. MillerAddress Elkridge Md.17. Burial Date thereof Apr. 17, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Madouridge Mem.Location Worsey Md.18. Funeral director F.P. Hays UndertakerAddress Elkridge City Md.19. April 15, 45 Miss E. Bird Miller
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 14 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
27 June 1944 to Apr 14 1945
 and that I last saw him alive on Apr 14 1945

Immediate cause of death

Cancer of Prostate
Metastasis
 Due to Broncho pneumonia

DURATION

1 yr.
3 mo.

Due to General arteriosclerosis
Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Brown
 Address Elkridge Md. M. D. or other
 Date signed 4/17/45

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County HowardCity or town near Laurel
If outside city or town limits, write RURAL and give nearest townHow long in above place of death? 69 yrs.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Laurel (North Laurel)
If outside city or town limits, write RURAL and give nearest townStreet No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Caroline Redmiles

3. (b) Social Security Number

4. Sex

F

5. Color or race

Wh

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Redmiles

7. Birth date of deceased (mo., day, yr.)

Sept. 12, 1875

8. If alive, give age _____ years

8. AGE:

Years 69 Months 6 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace

Savage, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

FATHER

12. Name

John Short

13. Birthplace

Md.

14. Maiden name

Unknown

15. Birthplace

Laurel, Md.

16. Informant

Hester Redmiles

Address

Laurel, Md.

17.

(Burial, cremation, or removal? Which?)

BurialDate thereof April 7, 1945
(month) (day) (year)

Cemetery or crematory

Savage, Md.

Location

Laurel, Md.

18. Funeral director

Laurel, Md.

Address

Laurel, Md.

19.

(Date rec'd by registrar)

4/6/45Frank Shipley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1937 to Apr 4 1945and that I last saw him alive on Apr 3 1945

Immediate cause of death

Myocardial failure

DURATION

1 day

Due to

Myocardial failure

Due to

10 yrs.

Due to

Arteriosclerosis

Due to

10 yrs.

Other conditions

Bilel. Cataracts

Other conditions

6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

J. M. Warren M.D.

M. D. or other

Address Laurel Date signed 4/6/45

RECEIVED
MAY 4 1945
BUREAU V.S.

(157-E)

Registration Dist. No. 194

If U. S. Veteran, specify WAR

(Usual place of abode)

If nonresident give city or town and State

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 29, 1985
(Month) (Day) (Year)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

22. I HEREBY CERTIFY, That I attended deceased from
April 28 1945 to April 29 1945

I last saw her alive on April 25, 1944; death is said to have occurred on the date stated above, at 5-0 m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Date of onset

"Short rate feature 7. Close

Other Contributory Causes of importance:

12. BIRTHPLACE (city or town) Clarksville md
(State or country)

FATHER

13. NAME Mr. Theodore Smith

14. BIRTHPLACE (city or town) Ind
(State or country)

MOTHER

15. MAIDEN NAME Laura Nelson

16. BIRTHPLACE (city or town) Idaho
(State or country)

17. INFORMANT Mr. Smith
• (Address) Chattanooga

18. BURIAL, CREMATION, OR REMOVAL
Place Los Angeles, Calif. Date April 29, 1944

19. UNDERTAKER *Mrs. Smith*
(Address)

20. FILED April 29, 1945 S. Q. Kricher Registrar.

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) L. A. Trachsel M. D.
(Address) Chapel Hill, N.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting "U. S. No. 1."

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

Reg. Diat. No. TH

1. PLACE OF DEATH:

County Howard
 City or town Mariettaville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4.5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard
 City or town Mariettaville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Heika Sweep

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed8.(b) Name of husband or wife Berk Sweep7. Birth date of deceased (mo., day, yr.) Nov. 24, 1864

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

80413

hrs.

min.

9. Birthplace Holland

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home

FATHER

12. Name Mcindat Briens13. Birthplace Holland

MOTHER

14. Maiden name unk15. Birthplace unk16. Informant Miss Jennie SweepAddress Mariettaville, Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 9, 1945

(month) (day) (year)

Cemetery or crematory Mt View CemeteryLocation Howard Co, Md18. Funeral director C. Harry WilesAddress Sylmarville, Md19. April 9

(Date rec'd by registrar)

19 45C. Harry Wiles

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 919 45 at 1:55 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19 44 to April 8 19 45and that I last saw him alive on April 6 19 45

Immediate cause of death

DURATION

Coronary atherosclerosis
myocardial infarction
Int. Nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE N.H. Barnes MD

M. D. or other

Address Sylmarville, MdDate signed 4/9/45

UNITED STATES DEPARTMENT OF STATE

THE SECRETARY OF STATE

CERTIFICATE OF DEATH

RECEIVED
APR 13 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04022
Reg. Dist. No. 191

1. PLACE OF DEATH: County... <u>Howard</u> City or town... <u>Prine Orchard</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>md</u> County... <u>Howard</u> City or town... <u>Prine Orchard</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>Irish Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war		
3.(a) FULL NAME <u>Charity Olivia Walcott</u>			3.(b) Social Security Number		
4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>married</u>			
8.(b) Name of husband or wife <u>Curtis Walcott</u>			6.(c) If alive, give age... years		
7. Birth date of deceased (mo., day, yr.) <u>Nov. 29, 1879</u>					
8. AGE:	Years <u>65</u>	Months <u>4</u>	Days <u>24</u>	if less than one day hrs. min.	
9. Birthplace... <u>Maryland</u> (Town, county, and state)					
10. Usual occupation... <u>at home</u>					
11. Industry or business					
FATHER	12. Name... <u>Joseph Selby</u>				
	13. Birthplace... <u>md.</u>				
MOTHER	14. Maiden name... <u>Mary Grimes</u>				
	15. Birthplace... <u>md.</u>				
16. Informant... <u>Mrs. August Selgoish</u> Address... <u>Ellicott City Md.</u>					
17. <u>Burial</u> (Burial, cremation, or removal. Which?) Date thereof... <u>4-26-45</u> (month) (day) (year) Cemetery or crematory... <u>mt view</u> Location... <u>alpha md.</u>					
18. Funeral director... <u>J. H. Whitten</u> Address... <u>Ellicott City Md.</u>					
19. <u>April 23, 1945</u> John B. Loughran (Date rec'd by registrar) Registrar					
MEDICAL CERTIFICATION 20. DATE OF DEATH... <u>April 23</u> 19 <u>45</u> , at <u>5¹⁰</u> P. M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 9, 1945</u> , to <u>April 23, 1945</u> and that I last saw him alive on <u>April 23, 1945</u> Immediate cause of death... <u>Heart Block</u> Due to... <u>arteriosclerotic changes - vascular disease</u> Due to... Other conditions... (Include pregnancy within 3 months of death) Major findings of operations... Date of op... Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide... Date of... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE... <u>Simmond Goldberger M.D.</u> Address... <u>Ellicott City Md.</u> Date signed... <u>4/23/45</u>					

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, N.Y.

NOTARY PUBLIC

RECEIVED
APR 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03768

19/30

1. PLACE OF DEATH:

County Baltimore Howard

City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month

Hospital, institution, or street address where death occurred:
Pinel Clinic

How long in hospital or institution? one month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County

City or town Lynchburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2477 Rivermont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edgar C. Wiley

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
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6.(b) Name of husband or wife Maude Stanley Wiley

June 28, 1869 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1869

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>9</u>	<u>15</u>	hrs. min.

9. Birthplace Independence, Va.
(Town, county, and state)

10. Usual occupation Engineer -- consultant

11. Industry or business

12. Name E. R. Wiley

13. Birthplace Greensboro, N. C.

14. Maiden name Nancy Bedwell

15. Birthplace Va.

16. Informant Maude S. Wiley

Address 2477 Rivermont Ave., Lynchburg, Va.

17. Burial Date thereof 4/14/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springhill

Location Lynchburg, Va.

18. Funeral director John D. Mitchell & Sons, Inc.

Address 1900 Eutaw Place, Baltimore, Md.

19. 4/12 85 AW Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 45 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 45 to April 12 19 45

and that I last saw him alive on April 12 19 45

Immediate cause of death Bronchopneumonia

Due to Generalized arteriosclerosis

cardiovascular heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ken A. Kozhman, M.D.

Address Ellicott City, Md. M. D. or other

Date signed 4/12/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.